# STATE OF UTAH
# DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
# APPLICATION FOR LICENSURE

# NATUROPATHIC PHYSICIAN

DOPL-AP-072 REV 06/07/2001

## APPLICATION INSTRUCTIONS AND INFORMATION

**General Statement:** The Division desires to provide courteous and timely service to all applicants for licensure. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents and fees.** The fees are for processing your application and will not be refunded. Failure to complete the application and supply necessary information may result in denial of licensure. Please read all instructions carefully.

**Address of Record:** The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address. Please note that the address of record is public information and is available upon request and via the internet. You may choose to use a business address or a P.O. Box for your address of record rather than your home address.

**Social Security Number:** Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

**Supporting Documents and Fees:**

1. Submit an official transcript from a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education, which includes your date of graduation and degree earned.

2. Submit official score results verifying your having passed the Naturopathic Physicians Licensing Examinations (NPLEX). (See "Additional Important Information" section below.)

3. Submit one of the following to document meeting the postgraduate residency requirement.

    - An "Evaluation of Postgraduate Training" form from each of your residency programs to

document having successfully completed at least 12 months of postgraduate training in a program associated with an accredited school or college of naturopathic medicine.

Request that the Preceptor complete the form and mail it directly to the Division. Evaluations will not be accepted from administrative personnel. Letters of recommendation will not be accepted in lieu of the evaluation form.

OR

- Documentation of at least 6,000 hours of active practice as a naturopathic physician during the five years immediately preceding the date of this application, if applying by endorsement.

4. Submit the original letter from Experior which documents your passing score on the Utah Naturopathic Physician Practice Act Law and Rule Examination.

5. Using the "Request For Verification of License" form, obtain verification of licensure from every state in which you have ever been licensed as a health care professional.

   Request that the verifying state(s) complete the form(s) and mail or fax them directly to the Division or return them to you for submission with your application.

6. If you are applying for a **temporary license**, additionally submit a "Request for Temporary License to Engage in a Supervised Residency Program" form, if you have met all requirements except completing the required residency program.

7. Submit the appropriate non-refundable application processing fee.

   - $100.00 for a Naturopathic Physician license.

   - $150.00 for a Naturopathic Physician and a temporary license.

**Additional Important Information:**

1. **Law and Rules Exam:** All applicants for licensure must pass the Utah Naturopathic Physician Practice Act Law and Rule Examination. Contact Experior at the address and telephone number below to register for the examination.

   Experior, 5486 South 1900 West, Suite C, Taylorsville, Utah 84118, (801) 355-5009.

   You may also purchase a study guide from Experior which has been prepared to assist candidates taking law exams.

   In addition, the following applicable laws and rules are available on the Internet at

http://www.commerce.state.ut.us/dopl/dopl1.htm.

- Division of Occupational & Professional Licensing Act
- General Rules of the Division of Occupational & Professional Licensing
- Utah Naturopathic Physician Practice Act
- Utah Naturopathic Physician Practice Act Rules

2. **Requirements For Licensure:** All applicants for licensure as a Naturopathic Physician must meet the requirements as detailed in the Utah Naturopathic Physician Practice Act and Rules. Additional requirements may be found in the Division of Occupational and Professional Licensing Act and Rules. Requirements include **but are not limited** to the following.

- An earned degree of doctor of naturopathic medicine from:

  a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education;

  a naturopathic medical school or college that is a candidate for accreditation by the Council of Naturopathic Medical Education; or

  a naturopathic medical school or college which, at the time of the applicant's graduation, met current criteria for accreditation by the Council of Naturopathic Medical Education.

- Successful completion, after completing the above educational requirement, of 12 months of clinical experience in naturopathic medicine in a residency program associated with an accredited school or college of naturopathic medicine under the preceptorship of a licensed naturopathic physician, physician and surgeon, or osteopathic physician.

- Pass the licensure series as outlined below.

- The ability to read, write, speak, understand, and be understood in the English language.

- Meet with the Naturopathic Physicians Licensing Board, if requested.

3. **Requirements for licensure by Endorsement:**

- Be currently licensed in good standing in another jurisdiction.

- Have met all the above requirements for licensure except the clinical experience requirement.
- Have been actively engaged in practice as a naturopathic physician for not less than 6,000 hours during the five years immediately preceding the date of application in Utah.

4. **Examinations:** Applicants must pass the required national examinations.

   - NPLEX Basic Science Series; OR State of Washington Basic Science Series OR State of Oregon Basic Science Series.
   - NPLEX Clinical Series.
   - NPLEX Homeopathy.
   - NPLEX Minor Surgery.

5. **Temporary License:** A temporary license to engage in a supervised residency program may be issued for no more than 18 months to an applicant who has met all the requirements for licensure except completion of a 12 month residency program. The temporary license can not be renewed or extended. Upon completing the supervised residency program, it is the responsibility of the applicant to submit to the Division an "Evaluation of Postgraduate Training" form from an approved preceptor documenting successful completion of the residency program. Upon receipt of the documentation, the Division will issue an active license to practice as a Naturopathic Physician in the State of Utah. The $150.00 application fee for temporary license includes the fee for the Naturopathic Physician license application. No additional fees are required.

6. **Approved Formulary:** Naturopathic Physicians licensed in the State of Utah after July 1, 1996, are required to limit their prescriptive practice to homeopathic remedies and to the list of legend medications established by rule (Aformulary@). As of this date there is not a currently established formulary. It is anticipated that the formulary will be established and printed in Rule by the end of 1999. A naturopathic physician is prohibited from prescribing any legend medications until the formulary is approved and published in Rule, and then may only prescribe those medications which are included in the Formulary. The Formulary will be available on our website as specified above.

7. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.

8. **License Renewal:** Each Naturopathic Physician license expires May 31 of each even numbered year. In order to renew your license you must complete at least 24 hours of approved continuing education.

9. **Updating Address Information:** It is a licensee's responsibility to maintain a current address with the Division. If your address is incorrect, you will not receive renewal notices or other correspondence.

**Make Licensure Fees Payable To**:

DOPL

**Mail Complete Application To:**

**By U.S. Mail**

Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

**By Delivery or Express Mail**

Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

**Telephone Numbers:**

| | |
|---|---|
| Direct Dial: | (801) 530-6633 or<br>(801) 530-6619 |
| Utah Toll Free: | (866) ASK-DOPL<br>(866) 275-3675 |
| **Fax Number:** | (801) 530-6511 |

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# APPLICATION FOR LICENSE or CERTIFICATE or REGISTRATION

**GENERAL INFORMATION**

License/Certificate/Registration Applying For: _____

Social Security Number: _____

Last Name: _____Maiden Name:_____

First Name: _____Middle Name: _____

Have You Ever Held A Utah License Before? Yes_____ No_____

If Yes, Name of Profession: _____

If Yes, License Number:_____

Gender (Male or Female):_____Date of Birth:_____

**PUBLIC MAILING ADDRESS**

Street:_____

City:_____State:_____Zip:_____

County:_____

Telephone:_(____)_____

**DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY**

License/Certificate Number: _____

Date License/Certificate Approved:_____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: _____

Reason For Denial/Other Comments: _____

**APPLICATION FOR:**

_____ Naturopathic Physician License

_____ Naturopathic Physician Temporary License

**NATUROPATHIC MEDICAL SCHOOL (Use additional sheets if necessary):**

Name: _____ Dates Attended: _____ To _____

Location: _____

Degree Received:_____ Date of Graduation: _____

**GRADUATE MEDICAL EDUCATION OR TRAINING**:

Complete the information below and account for **all** periods of training or postgraduate work from the time you graduated from naturopathic medical school. Use additional sheets if necessary.

Answer "Yes" or "No"

_____I have successfully completed a 12 month residency program associated with a Naturopathic Medical school accredited by the Council of Naturopathic Medical Education.

_____I am applying for a temporary license to engage in a 12 month residency program associated with a Naturopathic Medical School accredited by the Council of Naturopathic Medical Education.

_____I have practiced as a licensed naturopathic physician for at least 6,000 hours in the last 5 years preceding the date of this license application.

**POSTGRADUATE RESIDENCY:**

Complete the information below and account for **all** periods of supervised postgraduate residency program experience associated with a Naturopathic Medical School accredited by the Council of Naturopathic Medical Education. Attach additional sheets if necessary.

1. Name of Hospital or Treatment Facility: _____

   Address: _____

   Department: _____Telephone: _____

Date Began: _____ Date Ended:_____Total Hours Worked:_____

Name of Supervisor: _____ License No.:_____ _____

Duties and Responsibilities:_____

_____

2. Name of Hospital or Treatment Facility: _____

Address: _____

Department: _____Telephone: _____

Date Began: _____ Date Ended:_____Total Hours Worked:_____

Name of Supervisor: _____ License No.:_____

Duties and Responsibilities:_____

_____

**LICENSED PRACTICE:**

Account for all licensed naturopathic physician experience. You must have at least 6,000 hours in the last 5 years preceding the date of this application, if you are applying by endorsement. Attach additional sheets if necessary.

1. Name of Hospital or Treatment Facility: _____

Address: _____

Department: _____Telephone: _____

Date Began: _____ Date Ended:_____Total Hours Worked:_____

Name of Person Who Can Verify Your Licensed Experience: _____

Duties and Responsibilities:_____

_____

2. Name of Hospital or Treatment Facility: _____

Address: _____

Department: _____Telephone:_____

Date Began: _____ Date Ended:_____Total Hours Worked:_____

Name of Person Who Can Verify Your Licensed Experience: _____

Duties and Responsibilities:_____

_____

3. Name of Hospital or Treatment Facility: _____

Address: _____

Department: _____Telephone: _____

Date Began: _____ Date Ended:_____Total Hours Worked:_____

Name of Person Who Can Verify Your Licensed Experience: _____

Duties and Responsibilities:_____

_____

4. Name of Hospital or Treatment Facility: _____

Address: _____

Department: _____Telephone: _____

Date Began: _____ Date Ended:_____Total Hours Worked:_____

Name of Person Who Can Verify Your Licensed Experience: _____

Duties and Responsibilities:_____

_____

**PROFESSIONAL EXAMINATION REQUIREMENT:**

Answer "Yes" or "No"

_____NPLEX Basic Science Series, Date(s) Taken: _____

_____Washington Basic Science Series, Date(s) Taken: _____

_____Oregon Basic Science Series, Date(s) Taken: _____

_____NPLEX Clinical Series, Date(s) Taken: _____

_____NPLEX Homeopathy, Date(s) Taken:_____

_____NPLEX Minor Surgery, Date(s) Taken: _____

_____Utah Naturopathic Physician Practice Act Law and Rule Exam, Date(s) Taken: ____

**LICENSES:**

List all licenses, registrations, or certifications issued by any state which you now hold or have ever held in any health care profession. Use additional sheets if necessary.

Issuing State: _____

Profession:_____

Issuing State: _____

Profession:_____

Issuing State: _____

Profession:_____

# NATUROPATHIC PHYSICIAN
# QUALIFYING QUESTIONNAIRE

Answer "yes" or "no" for each question. Do not leave any question blank.

1. _____Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?

2. _____ Have you ever been denied the right to sit for a licensure examination?

3. _____Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

4. _____Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?

5. _____Are you currently under investigation or is any disciplinary action pending against you now by any professional licensing agency?

6. _____Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

7. _____Have you ever been permitted to resign or surrender hospital or other health care facility privileges while under investigation or while action was pending against you by any health care profession licensing agency, hospital, or other health care facility or criminal or administrative jurisdiction?

8. _____Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?

9. _____Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?

10. _____Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any health care profession licensing agency, hospital, or other health care facility or criminal or administrative jurisdiction?

11. _____Is any action pending against you now by Medicaid, Medicare, or any other state or

federal health care payment reimbursement program?

12. _____Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?

13. _____Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility or criminal or administrative jurisdiction?

14. _____Is any action pending against you now by either the federal Drug Enforcement Administration or any state drug enforcement agency?

15. _____ Have you been named as a defendant in a malpractice suit?

**If you answered Ayes@ to question 15, for each malpractice suit filed against your license, supply the date, status, disposition, amount of settlement, and a detailed description including your relationship to the patient and your role in the case.**

16. _____Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?

17. _____Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?

18. _____If you are licensed in the health care profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?

19. _____Are you currently using or have you recently (within 90 days) used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?

20. _____Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

21. _____Have you been arrested for or charged with a misdemeanor or felony charge in any

jurisdiction during the last 10 years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

22. _____Have you ever pled guilty to, no contest to, or been convicted of any felony or misdemeanor in any jurisdiction?

**If you answer "yes" to question 21 or 22 you must include with your application a copy of the police report, court docket, and any probation/parole officer report for EACH and EVERY arrest and/or conviction within the past ten years.**

23. _____Have you ever been involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

24. _____ Have you ever been terminated from a position because of drug use or abuse?

25. _____ Have you ever been incarcerated for any reason in any Federal, State or County Correctional Facility?

If you answered "yes" to any of the above questions, please enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean that you will not be granted a license; however, additional documentation may be requested by the Division if the information submitted is insufficient.

# AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meets the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant:_____

Date of Signature:_____

Printed Name of Applicant: _____

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Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

# EVALUATION OF POSTGRADUATE TRAINING

**TO BE COMPLETED BY APPLICANT:**

Request that the Preceptor complete this form and mail it directly to the Division. **Evaluations will not be accepted from administrative personnel. Letters of recommendation will not be accepted in lieu of this form.**

Applicant Name: _____

Applicant Address: _____

Name of Evaluating Hospital/Institution: _____

Department: _____From (Mo/Yr)_____To (Mo/Yr) _____

Type of Postgraduate Training: _____Internship _____Residency _____Fellowship

I hereby authorize release to the Utah Division of Occupational and Professional Licensing any files, records or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure as a physician and surgeon.

Applicant Signature: _____Date: _____

**TO BE COMPLETED BY EVALUATING PHYSICIAN**:

Name of Evaluating Physician (Please Print):

Title:_____ Phone No.:_____

This evaluation is based on: _____ Personal Knowledge _____ Review of Credential File

How long have you known the applicant? years_____months _____

Is this training program associated with an accredited naturopathic medical school or college?
_____Yes _____No Name of College: _____

**Please answer "yes" or "no" for each question. Please do not leave any question blank.**

1. _____Are the dates provided by the applicant on the top portion of the form accurate?

   If no, please indicate the period of program: From _____/_____To _____/_____

2._____Is the applicant related to you?

3. _____Do you know the applicant well?

4._____Has your acquaintance with applicant continued until recent dates?

5. _____Do you consider the applicant reliable?

6. _____Do you consider the applicant ethical?

7. _____Do you consider the applicant to be of good character?

8. _____Has the applicant, to your knowledge, ever been guilty of fraud or dishonesty?

9. _____Has the applicant, to your knowledge, ever been guilty of unprofessional conduct?

10. _____If the English language is not the native language of this applicant, do you feel that he/she has the ability to adequately communicate in the English language?

11._____To your knowledge, has the applicant ever been warned, censored, disciplined, had admissions monitored or privileges limited?

12. _____To your knowledge, has the applicant ever been asked to leave a training or post-graduate program?

13._____Did the applicant successfully complete this training program?

14._____Do you have any reservations about recommending the applicant for licensure? If yes, please explain on attached sheet.

15._____Is there anything else you think we should be aware of in evaluating this applicant for licensure? If yes, please explain on attached sheet.

16. Please rate the applicant=s:

Professional Ability: ____ Excellent _____Good _____Average _____Adequate _____Poor
Attention to Duties: ____Excellent _____Good _____Average _____Adequate _____Poor
Breadth of Education: ____Excellent _____Good _____Average _____Adequate _____Poor
Interpersonal Skills: ____Excellent _____Good _____Average _____Adequate _____Poor

All reports received by the Division of Occupational and Professional Licensing on a licensure applicant are confidential and are not subject to disclosure. However, the board must disclose such reports if they are relied upon in a contested denial of licensure.

Evaluating Preceptor's Signature: _____ Date:__ _____

Division of Occupational & Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 841114-06741

# REQUEST FOR TEMPORARY LICENSE TO ENGAGE IN A SUPERVISED RESIDENCY PROGRAM

**TO BE COMPLETED BY THE APPLICANT**:

Request that your Residency Supervisor complete this form and return it to you for submission with this application.

Applicant Name: _____

Applicant Address: _____
Name of Hospital or Treatment Facility Where Supervision Will Take Place:_____

Address of Hospital or Facility:_____

**TO BE COMPLETED BY THE RESIDENCY SUPERVISOR:**

Please complete this form and the affidavit and return it to the applicant for submission with his/her application for licensure.

Name of Licensed Supervisor (please print):_____

License Classification:

_____Naturopathic Physician

_____Physician and Surgeon

_____Osteopathic Physician and Surgeon

Utah License Number:_____

Supervisor=s Address: _____
Supervisor=s Telephone: _____

**AFFIDAVIT**

I attest under penalty of perjury as follows:

I am the Residency Supervisor of :_____(Name of Applicant)

I certify that this residency program is associated with a naturopathic medical school or college accredited by the Council of Naturopathic Medical Education.

I certify that I am responsible to provide direct supervision of the applicant, which means that I am responsible for the naturopathic activities and services performed by the applicant and I will be either in the facility or available by voice communication to direct and control the naturopathic activities and services performed by the applicant.

I certify that I have read and understand the Naturopathic Physician Licensing Act and Rules and that I will insure that the applicant complies with the Naturopathic Law and Rules, and that I will immediately report any violation to the Division.

I will immediately notify the Division of any change in status or termination of the residency program.

Signature of Supervisor:_____ Date: _____

Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
FAX: 801-530-6511

# REQUEST FOR VERIFICATION OF LICENSE

**TO BE COMPLETED BY THE APPLICANT:**

Request that the verifying state complete the form and mail or fax it directly to the Division or return it to you for submission with your application

Applicant Name: _____

Street Address: _____

City: _____

State:_____ Zip: _____

I am requesting licensure in the State of Utah as a _____

I am/have been licensed in your State under the name _____

My Social Security Number is _____

My Date of Birth is _____

My license number in your State is/was _____

I have enclosed the necessary license verification fee in the amount of $ _____

Signature of Applicant: _____

**TO BE COMPLETED BY THE VERIFYING AGENCY:**

Please furnish the information requested, sign and verify the document, and mail or fax it directly to the Division or place the completed form in an envelope, seal the envelope and provide it to the applicant in person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (as it appears in verifying state's records): _____

Classification of License Issued:_____

License Number: _____

Current Status: _____

Original Date of Licensure:_____

Expiration Date: _____

Continuously Licensed:

_____Yes _____No, please elaborate_____

Licensed By:

_____Exam, Type:_____Date: _____

_____Endorsement, From What State: _____

Examination Scores:_____

Education Required For Licensure:_____

Disciplinary Action or Pending Disciplinary Action:

_____No _____Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title:_____

Agency:_____

Date: _____

(SEAL)